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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 30 day rental ERMI Rt shoulder flexionater and Rt Elbow extensionater

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that medical necessity for the requested 30 day rental ERMI Rt shoulder flexionater and Rt Elbow extensionater is not established at this time

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx when she fell injuring her right shoulder. The patient was status post right shoulder rotator cuff repair on 03/20/14. The patient was followed for a period of post-operative physical therapy through 07/14. Despite post-operative physical therapy the patient continued to have difficulty with range of motion involving the right shoulder. The patient also had limited benefit in the long term from multiple injections of the right shoulder. The clinical record from 01/13/15 noted persistent pain in the right shoulder. The patient was unable to obtain approval for further surgical intervention for the right shoulder.
Physical examination noted positive impingement signs in the right shoulder with moderate tenderness over the biceps head and distal supraspinatus tendon. Range of motion was restricted on abduction to 80 degrees and flexion to 70 degrees. Recommendations were for referral to a functional capacity evaluation and work conditioning program. The requested rental of ERMI flexionator and elbow extensionator was denied on 11/21/14 and 01/16/15 as there was limited support and guidelines regarding its benefit for the treatment of adhesive capsulitis. Overall the rationale was limited regarding the expected outcomes from the use of a flexionator and extensionator.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has had persistent complaints of right shoulder pain despite the prior rotator cuff repair in 05/14 with subsequent injections and post-operative physical therapy. The most recent physical therapy the most recent clinical evaluation noted ongoing loss of range of motion primarily on abduction and flexion. Presentation is consistent with adhesive capsulitis for which flexionator and extensionator systems have limited evidence regarding their efficacy. The clinical records recommended a work conditioning program; however, it is unclear whether the patient attended a work conditioning program or had any substantial benefit from this program. Due

to the lack of evidence regarding the benefits from shoulder extensionators and lack of clinical documentation regarding specific functional improvements expected to be gained with use of requested flexionator and extensionator it is the opinion of this reviewer that medical necessity for the requested 30 day rental ERMI Rt shoulder flexionater and Rt Elbow extensionater is not established at this time and prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)